The Brain Spa LLC

210 Jupiter Lakes Blvd
Bldg. 3000
Suite 102
Jupiter, FL 33458

Psychiatrist	Psychiatric Nurse Practitioner	Psychologist	Counselors
Dr. Edward Barias, MD	Jennifer Bruk, FNP, PMHNP-BC	Dr. Joanna Peros, Psy.D., RN	Kai Johnson, LMHC, LMFT, MCAP
Dr. Jeffry Nurenberg, MD	Allison Long, MSN, APRN, PMHNP-BC		Valene Gifford, MS, LMHC
	Linda Morris, PHD, APRN, PMHNP-BC		Nina Chaitin, LMHC,QS
	Christine Barbato, APRN, PMHNP-BC		

Patient Name: _____ Female: ☐ Male: ☐

Date of Birth: _____ SSN #:_____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

How would you like us to confirm appointments? E-mail ☐ Text ☐ Both ☐

Emergency Contact: _____ Relationship: _____

Phone: _____ E-mail:_____

Primary Care Physician: _____

Phone:_____ Fax:_____

Preferred Pharmacy: _____Phone: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Whom May we Thank for Referring You to Us: _____

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Payment Method:

If you have Medicare please list secondary insurance information. If a secondary is not listed, we will take it as you are responsible for the remaining 20% after Medicare covers their 80%.

Self-Pay ☐ Insurance ☐ (if insurance complete section below)

Insurance Company: _____

ID #: _____

Group #: _____

Phone #: _____

Secondary Insurance Company: _____

ID #: _____

Group #: _____

Phone #: _____

Guarantor (Insurance Policy Holder Info.): Self ☐

Please complete section below if other than the patient.

Name: _____ Female: ☐ Male: ☐

Date of Birth: _____ SSN #:_____

Address (if different form patient): _____

City: _____ State: _____ Zip Code: _____

Employee Assistant Program (EAP)

Authorization Code: _____

Number of visits: _____

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Office E-mail: info@thebrainspa.net

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Current Symptoms Checklist:

(Check once for any symptoms present)

Depressed mood☐	Racing thoughts☐	Excessive worry☐
Unable to enjoy activities ☐	Impulsivity ☐	Anxiety attacks ☐
Sleep pattern disturbance ☐	Increase risky behavior ☐	Avoidance ☐
Loss of interest ☐	Increased libido ☐	Hallucinations ☐
Concentration/forgetfulness ☐	Decrease need for sleep ☐	Suspiciousness ☐
Change in appetite ☐	Excessive energy ☐	Excessive guilt ☐
Increased irritability ☐	Fatigue ☐	Crying spells ☐
Decreased libido ☐		

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? Yes ☐ No ☐
If yes, for which substances? _____
If yes, where were you treated and when?_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
Have you ever felt you ought to cut down on your drinking or drug use? Yes ☐ No ☐
Have people annoyed you by criticizing your drinking or drug use? Yes ☐ No ☐
Have you ever felt bad or guilty about your drinking or drug use? Yes ☐ No ☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? Yes ☐ No ☐
Do you think you may have a problem with alcohol or drug use? Yes ☐ No ☐
Have you used any street drugs in the past 3 months? Yes ☐ No ☐ If yes, which ones?

_____

Have you ever abused prescription medication? Yes ☐ No ☐ If yes, which ones and for how long? _____

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Reason for the visit today:

_____

_____

Current Medications:

Medication	Dosage	Frequency

Allergies: N ☐/ Y ☐ (if yes please list below):

_____

_____

Past Medical History

_____

_____

Past Psychiatric History: Outpatient treatment: Yes ☐ No ☐
If yes, please describe When, Where, and nature of treatment.

_____

_____

Psychiatric Hospitalization: Yes ☐ No ☐
If yes, describe for what reason, When and Where.

_____

_____

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Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

DIAGNOSIS	YES	NO	WHICH FAMILY MEMBER?
Bipolar disorder	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Anger	☐	☐	
Suicide	☐	☐	
Schizophrenia	☐	☐	
Post-traumatic stress	☐	☐	
Alcohol abuse	☐	☐	
Other substance abuse	☐	☐	
Violence	☐	☐	

Has any family member been treated with a psychiatric medication? Yes ☐ No ☐
If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Is there any additional personal or family medical history? Yes ☐ No ☐
If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? Yes ☐ No ☐ If yes, please explain:

_____

_____

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Personal and Family Medical History:

MEDICAL CONDITION	YOU	FAMILY	WHICH FAMILY MEMBER
Thyroid Disease	☐	☐	
Anemia	☐	☐	
Liver Disease	☐	☐	
Chronic Fatigue	☐	☐	
Kidney Disease	☐	☐	
Diabetes	☐	☐	
Asthma/respiratory problems	☐	☐	
Stomach or intestinal problems	☐	☐	
Cancer (type)	☐	☐	
Fibromyalgia	☐	☐	
Heart Disease	☐	☐	
Epilepsy or seizures	☐	☐	
Chronic Pain	☐	☐	
High Cholesterol	☐	☐	
High blood pressure	☐	☐	
Head trauma	☐	☐	
Liver problems	☐	☐	
Other:	☐	☐	

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TREATMENT CONSENT FORM: Please read carefully, initial on each page, sign, and date on the last page.

SERVICES OFFERED:

Psychiatric

Psychiatric evaluation Will be performed at your initial appointment. Dr. Barias, Dr. Nurenberg or one of our psychiatric nurse practitioners Jennifer Burk, FNP, PMHNP-BC, Allison Long, MSN, APRN, PMHNP-BC, Linda Morris, PHD, APRN, PMHNP-BC, Christine Barbato, APRN, PMHNP-BC will conduct a thorough review of your current ant past psychiatric issues, history, treatment and medications. By the end of your initial visit the provider will offer their preliminary assessment and discuss your treatment options. Sometimes, psychotherapy alone will suffice. Often, however, a combination of psychotherapy and medication management is optimal. One of the most important curative aspects of a therapeutic relationship is the goodness-of-fit between doctor, therapist & client. Our goal is to provide you a referral to one of our counselors, Dr. Peros, Kai Johnson, LMHC, LMFT, MCAP, Brian Chaitin, LMHC, Valene Gifford, MS, LMHC, Nina Chaitin, LMHC, QS and the providers will manage your medication, so you can reach the optimal benefits. Dr. Barias may also offer outpatient detox services. However, given the risks of detoxification; Dr. Barias may potentially recommend his patients to seek inpatient treatment or further hospitalization. If you refuse to follow the providers recommendations, you will free all providers and The Brain Spa LLC of any legal liability or legal actions. You agree by signing this document to be fully responsible of not following the recommendations. _____initials.

Psychotherapy

Psychotherapy, or talk therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relations, stress reduction, and a deeper insight into one's own life, values, goals, and development. It requires a great deal of motivation, discipline, and work on both parties for a therapeutic relationship to be an effective one. Client's will have varying success depending on the severity of their complaints, their capacity for introspection, and their motivation to apply what is learned outside of sessions.

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Medication

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, we will discuss with you the medication options that are available to treat your current condition. We will present information in language that you can understand. You will learn how the medication works, it's dosage and frequency, its expected benefits, possible side effects, drug interactions, any withdrawals affect you may experience as well as, if you stop taking the medication abruptly. By the end of the assessment, you will have all information you need to make a rational decision as to which medications are right for you. Medication refill will require a 48 hour notice.

If you are already receiving psychotherapy from another therapist and are referred to me for medication management, I will make a strong effort to coordinate care with your therapist. You will need to sign a consent. I believe communications between mental health professionals is key to providing effective care.

Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, and frequency, close follow up, and sometimes regular blood work. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy.

_____ Initials

Overall, I am a strong proponent of the bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, your psychological development, and social issues together will yield the best chance for success in achieving your goals.

Frequency and duration of visits

At your initial visit, we will decide together the structure of your therapy. If medications are prescribed, or changed, I prefer to conduct follow-up visits every two weeks to get your medications stabilized. This is necessary to ensure proper administration and minimize any side effect you may experience. If your symptoms improve, follow-up visits can be spaced out a monthly interval. For clients on maintenance therapy, follow-up visits can be held at three-months intervals. We may discuss an alternate treatment structure depending on your circumstances.

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Payments

Please note that all co-pay's, co-insurance, and/or deductibles are required to be paid at the time of service. We accept cash and major credit cards. If payment is 60 days past due, I reserve the right to utilize collection agencies and/or legal options to collect our fees.

Insurance Policies

We will accept your insurance if we are in-network. Co-Insurance/co-pays are paid at the time of service. Insurances are verified. Your deductible must be met or you will be responsible for any payment at the time of service. We can provide a statement if your wish to file for out of network benefits. Many insurance companies have limitations on the number and frequency of visits, and not all medications are covered. Occasionally, certain forms for treatment or prior authorization is required. We will need to provide information about your diagnosis, history and treatment plan to your insurance company.

Cancellation Policy

The Brain Spa providers are committed to providing our patients with exceptional care. We strive to see each patient as closely to their scheduled time as possible. When a patient cancels, misses an appointment or arrives after their scheduled time, they prevent other patients from being seen in a timely manner.

Please call us at 561-406-6561 forty-eight (48) hours prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call the office on Thursday. If prior notification is not given, you will automatically be charged $80.00 for the missed appointment.

Late Arrival Policy

Patients who arrive more than **10 minutes** after their scheduled appointment time will be rescheduled. After a second late arrival, a **$50.00 fee** will be charged in addition to a rescheduled appointment.

More than 3 missed appointments, either by no show or by late arrival will be eligible for discharge from the practice.

Each fee will be charged to the credit card on file associated with the account.

Client's signature: _____ Date: _____

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Credit Card Information:

Name on Credit/Debit Card: _____

Card Number: _____

Expiration Date: _____CVV Code: _____ Zip Code: _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other: _____

Billing Address for Card: _____

City: _____ State: _____ Zip: _____

Phone:_____ Email Address: _____

Cardholder's Signature (required): _____ Date: _____

The Brain Spa's Policy

If patients are unwilling to have a credit card on file with the practice, they will be required to pay an upfront fee of whatever the contracted rate would be with your insurance carrier. If you are a self-pay patient a $125.00 fee will be required upfront.

Medical Records

We are required by law to keep complete medical records. Most of our records will be electronic, encrypted, and secure. All paper records are kept in a locked cabinet. You are entitled to review your medical record at any time. If you wish to view your records, I recommend that we review them together to minimize any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying, and summarizing the medical record will be charged the appropriate fee.

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Confidentiality

The security of your sensitive information is of utmost importance and we are bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your written consent.

_____ Initials

There are exceptions to this confidentiality, where disclosure is mandatory. These include the following:

- If there is a threat to the safety of other's we are required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization.
- When there is a threat of harm to yourself, we are required to seek immediate hospitalization and will likely seek the aid of family member or friend to ensure your safety.
- In the case of legal hearings, you do have the right to refuse my involvement in the case.
- There are rare circumstances, however, in which we will be required by a judge to testify on your emotional, or cognitive condition.
- In situations where a dementing illness, epilepsy or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, we will be required to report this to the DMV.
- If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, we will be required to disclose information to seek hospitalization.

These situations rarely occur in an outpatient setting. If they do arise, we will do our best to discuss the situation with you before acting. In rare circumstances we may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them).

Contact information.

Our office phone number is 561-406-6561. This is the best way to contact us. We check our messages regularly. For all non-urgent matters, calls will be returned within 24 hours. Dr. Barias might provide his mobile phone under special circumstances, he will respond to text messages only. Make sure you leave your full name, your phone number (even if you think he has it), reason for the call and the best time to call you back. Dr. Barias will return your call at his earliest convenience. If you or someone close to you is in immediate danger call 911 or proceed to the nearest emergency room.

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Treatment consent

By signing below, you certify that you have read and understand the terms stated in the TREAMENT CONSENT FORM. You indicate that you understand and agree to the scope of our services, session structure, cancellation/no shows policies, payment policy, insurance reimbursement, confidentiality, the nature of our practice, and our contact policy. You are agreeing to abide by these terms during our therapeutic relationship.

Client's name (please print): _____ Date: _____

Client's signature: _____

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